

Correspondence

The Editorial Board will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words, and must be typewritten, double-spaced and submitted in duplicate (the original typescript and one copy). Authors will be given an opportunity to review any substantial editing or abridgment before publication.

Treatment for Heatstroke Victims

TO THE EDITOR: This is a further comment on thermal resuscitation of heatstroke victims (Elliston E: *West J Med* 133:255-256, Sep 1980).

Evaporative cooling has been shown to be highly effective and probably safer than whole body emersion in the emergency room treatment of hyperthermia.¹ However, initial cooling for heatstroke or hyperthermia must begin in the field and continue during transport under conditions where optimum use of evaporative cooling may be difficult to achieve.

Cold packs applied to areas of large superficial vessels (neck, axillary, inguinal) have been used successfully to treat heatstroke in distance runners. Recent case reports have shown body cooling from initial rectal temperatures from between 43° and 42°C (109.4° and 107.6°F) to between 39.5° and 39.0°C (103.1° and 102.2°F) in 20 to 30 minutes.^{2,3} This method has the advantage of immediate application and minimum cutaneous vasoconstriction.

Emergency medical crews should be instructed in rapid initiation of regional cooling for heatstroke victims using commercially available chemical cold packs.

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Tonsillectomy and Adenoidectomy

TO THE EDITOR: Several points come to mind after reading the article by Davidson and Calloway concerning tonsillectomy and adenoidectomy in the November 1980 issue.¹

- Any physician who is caring regularly for a patient and who allows the patient to progress to right ventricular failure due to correctable upper

airway obstruction, in my opinion could be guilty of criminal negligence.

- The streptococcus is not the only organism that causes tonsillitis, and cultures that only identify or exclude this organism may miss many bacterial infections.

- No mention was made in the article of chronic tonsillitis, the day-in and day-out chronic inflammation and infection of the tonsils. Chronic tonsillitis may well represent the only chronic infectious disease in the body, relatively easily corrected by a surgical procedure, that is accepted as a normal state.

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Radiation Therapy for Skin Cancer

TO THE EDITOR: In the November issue, Fischbach and colleagues state their case for the radiation therapy of skin cancer.¹ Unfortunately, their study and, therefore, their conclusions are marred by their woefully short follow-up. The authors do not provide data as to the length of follow-up except to state that there was a minimum two-year follow-up period, and "for most the period of evaluation was longer." Since the study was begun in 1969, and the paper published in 1980, ten years was the maximum follow-up—and for most it was obviously less.

The authors fail to recognize that any short-term conclusions regarding the results of radiotherapy of the skin are bound to be wrong. Numerous observations have shown that significant skin radiation—well below the doses used in radiotherapy of skin cancer—tends to result in carcinomatous degeneration decades later. Radiation scars are notorious for *late* recurrences or carcinomatous degeneration—it is often impossible to decide which mechanism is responsible.

Similarly, Fischbach's conclusions that "cosmetic and functional results were excellent" is

meaningless. Unlike surgical scars, which remain stationary or improve with time, radiation scars worsen with time. This is not just a cosmetic nuisance, but the gradually deteriorating appearance of a radiation scar often masks recurrent carcinoma within it.

It puzzles me why after 50 years of documentation of the insidious late effect of radiation on the skin, the short-term results of radiation therapy for skin cancer would be published. There are plenty of studies documenting the good *short-term* results of fractionated radiotherapy.

Most dermatologists avoid radiotherapy for skin cancer; we have seen too many bad late results. Possibly the more modern techniques of increased fractionation of the radiation dose—as used by Dr. Fischbach and associates—will provide better long-term results. The burden of proof is on those advocating radiotherapy; they must show that it is possible to dissociate the short-term good therapeutic results from the long-term complications of skin radiation. Until this proof is forthcoming, I believe radiotherapy of skin cancer should be limited to the very few patients who are unable to tolerate, or who refuse, surgical removal.

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Possible Hazards of Nylon Athletic Shorts

TO THE EDITOR: Nylon athletic shorts have become increasingly popular; recently, built-in nylon underwear has been added to this type of shorts. I have seen at least two cases of significant problems caused by nylon athletic shorts with built-in underwear. In the first instance, a patient, due to the poor insulating qualities of the nylon athletic shorts, developed penile frostbite during a 40-minute run in foggy 40°F weather; this resolved with warming of the involved part in 100°F water for 15 to 20 minutes. In the second instance, a patient presented with symptoms of urethritis. A workup was done for this diagnosis before it was found that he was a weight lifter who had recently switched to nylon athletic shorts; it was discovered that the urethral meatus was being irritated by the chafing of the nylon. It seems that wearing an athletic supporter or cotton underwear under nylon running shorts would

be prudent; this would decrease chafing and increase insulation. It likewise seems that fungal groin rashes would be more likely to occur where nylon running shorts frequently are worn alone.

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TdT Negative T-ALL

TO THE EDITOR: T acute lymphocytic leukemia (T-ALL) makes up about 30 percent of all cases of acute leukemia and can be characterized by the blasts which have the ability to form E rosettes, demonstrate the theta antigen and contain the enzyme terminal deoxynucleotidyl transferase (TdT).¹ The use of the TdT assays has been found to be extremely useful in distinguishing acute lymphocytic leukemia (ALL) from acute myelogenous leukemia (AML), or—more important—prednisone-vincristine responsive acute leukemia. Recently Saab and Carlsson reported a case of lymphoblastic leukemia without TdT.² We wish to report here the case of a patient with acute lymphocytic leukemia in whom the blasts were E rosette-positive and theta antigen-positive but in whom TdT was absent.

Report of a Case

A 62-year-old woman presented with a leukocyte count of 44,000 per cu mm, anemia, thrombocytopenia and uric acid nephropathy. The leukocyte count rose within 48 hours to 169,000 per cu mm and uremia supervened (uric acid peaked at 43 mg per dl). Hemodialysis and allopurinol therapy resulted in a reversal of the uric acid nephropathy. Findings on a bone marrow examination confirmed ALL. Once the renal status stabilized, vincristine and prednisone therapy produced a remission within approximately 14 days.

The patient refused maintenance chemotherapy, and overt relapse occurred six weeks later. Again, the leukocyte count rose suddenly and precipitously to 180,000 per cu mm. Vincristine, prednisone and doxorubicin hydrochloride (Adriamycin) were given. Within 24 hours the leukocyte count dropped and hypocalcemic, hyperphosphatemic tetany supervened (calcium, 5.5 mg per dl; potas-